JANET NAPOLITANO
GOVERNOR

RICHARD G. MAXON
ACTING DIRECTOR

STATE OF ARIZONA
ARIZONA DEPARTMENT OF VETERANS' SERVICES
ARIZONA STATE VETERAN HOME
4141 NORTH THIRD STREET
PHOENIX, ARIZONA 85012
PHONE (602) 248-1550 FAX (602) 297-6693

April 5, 2007

Donald F. Moore, R. Ph., MBA
Medical Center Director
Carl T. Hayden Veterans Affairs Medical Center
650 E. Indian School Road
Phoenix, AZ 85012-1892

Dear Director Moore:

We are requesting an amendment to our March 12, 2007, Plan of Correction to reflect the following:

- § 51.120.a **Quality of care – Reporting of Sentinel Events**.
  - Upon review of the regulation of the cited deficiency, our policy will continue to follow regulatory guidelines and timeframes for reporting root cause analysis to 45 days. The original Plan of Correction called for a 10-day reporting deadline, which is not correct.
- §§ 51-110.b.2, 51.110.b.3, 51.110.b.4 **Resident Assessment Frequency**
  - Audit tools # 5 and 7 will not be utilized. A comprehensive audit tool identifying *all components* of the resident chart and reviews are included in this audit. Since these audit tools had a more narrow scope than the audit being conducted, they are not necessary.

Questions on the addendum should be directed to me directly at (602) 248-1591 or to Mark Laney at (602) 263-1825 or on his cell phone at (602) 677-2604. Thank you for your assistance.

Sincerely,

Mike Landry
Assistant Deputy Director – Operations

cc: Richard G. Maxon, Acting Director – Arizona Department of Veterans' Services
Roberta Knapp, PT – Administrator of Geriatrics and Extended Care Services

STATE OF ARIZONA
ARIZONA DEPARTMENT OF VETERANS' SERVICES
ARIZONA STATE VETERAN HOME
4141 N. 3RD STREET
PHOENIX, ARIZONA 85012
(602) 248-1550 FAX (602) 263-1806

JANET NAPOLITANO
GOVERNOR

PATRICK F. CHORPENNING
DIRECTOR

March 12, 2007

Mr. Donald F. Moore, R.Ph., MBA, Director
Carl T. Hayden VA Medical Center
650 East Indian School Road
Phoenix, AZ 85012

Dear Mr. Moore:

Please find enclosed the completed plan of correction for the "partially met" and "not met" standards noted in the annual survey conducted 1/22/07 through 1/29/06.

Please convey to your survey team, my appreciation of their professionalism and patience throughout the survey process. We have several new additions to our administrative team, and for some this was their first experience with the VA annual review as well as being new to the long-term care industry.

If you and/or your team have any questions regarding this plan of correction, please do not hesitate to contact me at 602-248-1591 or our newly promoted Director of Nursing, Stephanie Talley, R.N., 602-248-1815.

Sincerely,

Catherine Corbin

Catherine Corbin, PhD, LNHA
Administrator

Enclosure

STATE OF ARIZONA
ARIZONA DEPARTMENT OF VETERANS' SERVICES
ARIZONA STATE VETERAN HOME
4141 N. 3RD STREET
PHOENIX, ARIZONA 85012
(602) 248-1550 FAX (602) 263-1806

JANET NAPOLITANO
GOVERNOR

PATRICK F. CHORPENNING
DIRECTOR

VA SURVEY PLAN OF CORRECTION

ARIZONA STATE VETERAN HOME

Presented March 12, 2007

§ 51.210.g.2 Staffing qualifications

Action Plan: Professional staff will be licensed, certified, or registered in accordance with applicable State laws.

Nursing Supervisor and/or designee will complete performance appraisals of each nursing staff member each year. The DON will review, sign and return to the Nursing Supervisor or designee. The Nursing Supervisor or designee will meet with each nursing staff member for review and signatures.

TARGET DATE: All performance appraisals forms of each staff member will be delivered to supervisors for completion and for scheduling a review time with staff members by April 6, 2007.

§ 51.210.k.2.ii Required training of nursing aides

Action Plan: Nursing aides will complete a training and competency evaluation program or a competency evaluation program approved by the State.

The facility will continue to mandate a general orientation class (see attachment #1) followed up with a post-class test. Staff Developer or designee will provide all newly hired C.N.A. with a competency skills checklist which needs to be completed and returned to the Staff Developer within 30 days of hire. Skill guidelines will also be provided for the C.N.A. for study reference. An annual certified nursing competency performance evaluation will be completed thereafter.

Staff Developer will track new hire and annual competency skill performance on an individual basis. Staff Developer will use the competency evaluation program to provide regular in-service education based on the outcome of the competencies. At least 12 in-service hours per year will be provided to meet standards.

TARGET DATE: The plan of action for C.N.A. competency program was presented to the Continuing Quality Improvement committee on February 20, 2007, for approval.

§ 51.210.l Proficiency of nurse aides

Action Plan: Performance appraisals will be reviewed with employees.

Nursing Supervisor and/or designee will complete performance appraisals of each nursing staff member each year. The DON will review, sign and return to the Nursing Supervisor or designee. The Nursing Supervisor or designee will meet with each nursing staff member for review and signatures.

TARGET DATE: All performance appraisals forms of each staff member will be delivered to supervisors for completion and for scheduling a review time with staff member by April 6, 2007.

§ 51.210.m.1. Laboratory services

Action Plan: The facility will provide or obtain laboratory services to meet the needs of its residents and will be responsible for the quality and timeliness of the services.

The Medical Records team will complete an audit every Monday and Tuesday of all active charts to ensure that: (1) all labs are noted and drawn in a timely manner, (2) all reports are in the charts and have been faxed to the physician, (3) all new admission orders have been signed by the physician. The audit will include checking to ensure that all admitting orders have been moved forward to a new date, if applicable, and have been entered into the computer.

TARGET DATE: All unit secretaries and medical records staff will be in-serviced regarding the audit protocol on March 12, 2007. (See attachment #2).

§ 51.210.o.5 Clinical record

Action Plan: The clinical record will contain the results of any pre-admission screening conducted by the State.

Current protocol states that all admissions will have a PASARR prior to admission and that Admissions has a thorough understanding of the purpose of PASARR. Once admitted, Social Services will assume responsibility for monitoring PASARR.

To address the immediate problem, all open charts were audited for correct PASARR's, thereby, ensuring that all level II's are being followed through and Level I's that should be Level II's are corrected.

A care plan checklist was developed (see attachment #5) to ensure compliance. This will be submitted to the CQI committee on March 20, 2007, for approval

TARGET DATE: All personnel with any responsibility for completing the PASARR will be trained/retrained on March 14, 2007.

§ 51.120.p.2.ii Quality assessment and assurance committee

Action Plan: The facility will develop and implement appropriate plans of action to correct identified quality deficiencies.

All deficiencies that have been identified will be brought to the Continuous Quality Improvement (CQI) Committee to be addressed monthly from conception to completion. From the CQI process, smaller works groups will be developed which will use the PLAN – DO – CHECK – ACT (PDCA) performance improvement procedure. PLAN: Devise or revise a process for improvement. DO: Implement the planned measure for performance. CHECK Assess the new idea(s) and report the results to the CQI committee. ACT: Decide on the changes needed to the original plan, receive approval from the administrator, and then implement. Once the idea is implemented, it will be brought back to CQI for tracking. The CQI coordinator will train the CQI members and create a pamphlet for reference (see attachment #3). CQI will continue to meet monthly and address areas for process improvement. Once the committee decides that the deficiencies have been fully addressed, improvement noted and measured, and all standards for quality met, the item will have a three month follow-up. At that time, if the process continues to be working, it will then be noted as a closed item on the CQI minutes, but monitoring will continue.

TARGET DATE: March 15, 2007, and ongoing.

§ 51.100 Quality of Life – Resident Council

The facility will document any concerns submitted to the management of the facility by the council which shall include resolutions.

Current action forms are now being sent out electronically to all department managers to improve response time regarding resident concerns. Recreation Therapy will ensure that 100% of resident concerns will have been addressed in a timely manner by the appropriate discipline with the concurrence of the administrator and any definite solutions documented. Any unresolved issues will be presented to the administrator and members of the CQI committee for multidisciplinary input in an effort to reach a resolution. Recreation Therapy will submit a log and/or report regarding resident concerns and resolutions at the monthly Continuing Quality Improvement meeting.

TARGET DATE: March 20, 2007, and ongoing.

§ 51.110.a. Resident assessment – Admission orders

Action Plan: Admission orders will be signed by a physician.

At the time each resident is admitted, the Admissions Coordinator or trained designee will have physician orders for the resident's immediate care and a medical assessment, including a history and physical examination, within a time frame appropriate to the residents' condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission, and the findings were recorded in the medical record on admission. Nursing will be in-serviced by the Staff Developer regarding VA admission processes and requirements by April 6, 2007.

The Medical Records team will complete an audit (see attachment #16) every Monday and Tuesday of all active charts to ensure that: (1) all labs are noted and drawn in a timely manner, (2) all reports are in the charts and have been faxed to the physician, (3) all new admission orders have been signed by the physician. The audit will include checking to ensure that all orders have been moved forward to a new date, if applicable, and have been entered into the computer.

Medical Records and Nursing staff will place all admitting orders in the M.D. folder for signature.

TARGET DATE: All unit secretaries and medical records staff will be in-serviced regarding the audit protocol on March 12, 2007. (See attachment #4).

§ 51.110.b.2.i. Resident assessment – Frequency

Action Plan: An assessment will be conducted 14 days after admission and promptly thereafter with any significant change in the resident's physical, mental, or social condition.

The MDS coordinator will be responsible for assuring that the scheduling and completion of the MDS will be kept within CMS timeframes. Training for the nursing staff currently responsible for MDS completion was conducted on February 27, 2007. Training consisted of review of MDS time frames and discussion regarding interdisciplinary input and charting. Care plans need to be resident-specific and goal-oriented. Prior history will be reviewed in relation to current conditions and addressed on care plan. New care plan and old care plan will be reviewed to see if there has been a significant change of condition. All Care Plan meetings will also have summary sheets with interdisciplinary input and assignments given for follow-up (see attachment #14). RAP sheets need to be referenced by date and triggers must be dated and referenced material must be dated. Cross-training for back-up personnel will occur by March 30, 2007. Additional staff will be added to the MDS department to include a clerk so that an MDS calendar, all necessary signatures, and the timely submission of MDS data can occur.

The Administrator and DON will meet with the care plan teams from each unit on a daily basis throughout the week of March 13 – 15, 2007 for training regarding CMS timeframes and to reinforce that the timely completion of the MDS is a mandate, not an option.

The Administrator, MDS Coordinator and IDT (Interdisciplinary Team) will ensure compliance at the time of all care conferences – admission, quarterly, and change of condition.

TARGET DATE: April 6, 2007, and ongoing.

§ 51.110.b.3. Resident assessment – Review

Action Plan: The nursing facility will examine each resident no less than every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

On February 13, 2007, all staff members who participate in developing Care Plans attending a training session on the re-structuring of our Care Plan Process utilizing the "Partners in Care-care planning conferences" video prepared by the American Health Care Association.

It is anticipated that Social Services will fill all vacancies and will be fully staffed within the next month.

On February 13, 2007, care plan members participated in a ½ hour training on Care Planning and Team Building. (See attachment #6) The following was recommended: (1) All care plan meetings will be attended by all disciplines to include a C.N.A., (2) ADL books will be reviewed and updated at the care plan conference, (3) an immediate audit was done of all charts using an audit tool (see attachment #7); all charts will be audited within the next 10 weeks, (4) audit sheet will go in the front of the chart being reviewed at the time of the Care Conference and will be signed by all members attending, (5) the audit will continue every 3 months to ensure ongoing compliance.

A care plan checklist was developed (see attachment #5) in order to identify any further problems with incorrect/unfinished charting. This will be submitted to the CQI committee on March 20, 2007, for approval.

Social Service Supervisor will conduct a social worker team meeting on March 26, 2007, where the following will be reviewed:

1. Admission Committee will identify any substance/alcohol/tobacco history of abuse and current practices.
2. All residents with history of substance abuse will be care planned, regardless of current use.
3. All residents will be interviewed and substance, alcohol and tobacco use documented. Screening will include type of substance, frequency of use, duration of use and any unusual habits that accompany the substance abuse. If tobacco abuse is indicated, then a complete smoking assessment will be completed and appropriate precautions taken.
4. Residents who continue to abuse the use of substances and alcohol will be referred for appropriate treatment.
5. If resident continue to abuse substances, treatment oriented discharge will be explored.
6. Should there be any change in these behaviors, the care plan assessment will be revised to reflect changes.

The Administrator, MDS Coordinator and IDT will ensure compliance at the time of all care conferences – admission, quarterly, and change of condition.

TARGET DATE: April 4, 2007, and ongoing.

§ 51.110.b.4. Resident assessment – Use

Action Plan: The results of the assessment will be used to develop, review, and revise the resident's individualized comprehensive plan of care.

On February 13, 2007, care plan members participated in a 1/2-hour training on Care Planning and Team Building. The following was recommended: (1) All care plan meetings will be attended by all disciplines to include a C.N.A., (2) ADL books will be reviewed and updated at the care plan conference, (3) An immediate audit was done of all charts using an audit tool (see attachment #7). All charts will be audited within the next 10 weeks. (4) The audit sheet will go in the front of the chart being reviewed at the time of the Care Conference and will be signed by all members attending. (5) The audit will continue every 3 months to ensure ongoing compliance.

Social Service Supervisor will conduct a social worker team meeting on March 26, 2007, where the following will be reviewed:

1. Admissions Committee will identify any substance/alcohol/tobacco history of abuse and current practices.
2. All residents with history of substance abuse will be care planned, regardless of current use.
3. All residents will be interviewed and substance, alcohol and tobacco use documented. Screening will include type of substance, frequency of use, duration of use and any unusual habits that accompany the substance abuse. If tobacco abuse is indicated, then a complete smoking assessment will be completed and appropriate precautions taken.
4. Residents who continue to abuse the use of substances and alcohol will be referred for appropriate treatment.

5. If resident continue to abuse substances, treatment oriented discharge will be explored.
6. Should there be any change in these behaviors, the care plan assessment will be revised to reflect changes.

The Administrator, MDS Coordinator and IDT will ensure compliance at the time of all care conferences – admission, quarterly, and change of condition.

TARGET DATE: April 4, 2007, and ongoing.

§ 51.110.d. Comprehensive care plans

Action Plan: The facility will develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs identified in the comprehensive assessment.

Comprehensive care plan training for all staff with input responsibilities and who make up the care plan team was conducted on February 27-28, 2007. CMS's RAI Version 2.0 manual has been printed and placed on each unit for staff reference. Training on the use of this manual was included in the comprehensive care plan training.

Review of care plan protocol will be conducted by the Social Service Supervisor for all social workers on March 19, 2007. Orientation protocol for any new social workers will be developed by the Social Service Supervisor.

A wander guard policy was developed (see attachment # 8) and will be submitted to the Continuing Quality Improvement Committee on March 20, 2007 for review and approval.

Social Service Supervisor will conduct a social worker team meeting on March 26, 2007, where the following will be reviewed:

1. Admissions Committee will identify any substance/alcohol/tobacco history of abuse and current practices.
2. All residents with history of substance abuse will be care planned, regardless of current use.
3. All residents will be interviewed and substance, alcohol and tobacco use documented. Screening will include type of substance, frequency of use, duration of use and any unusual habits that accompany the substance abuse. If tobacco abuse is indicated, then a complete smoking assessment will be completed and appropriate precautions taken.
4. Residents who continue to abuse the use of substances and alcohol will be referred for appropriate treatment.
5. If resident continue to abuse substances, treatment oriented discharge will be explored.
6. Should there be any change in these behaviors, the care plan assessment will be revised to reflect changes.

The Administrator, MDS Coordinator and IDT will ensure compliance at the time of all care conferences – admission, quarterly, and change of condition.

TARGET DATE: April 6, 2007, and ongoing.

§ 51.110.d.2.i. Comprehensive care plans

Action Plan: A comprehensive care plan will be completed within 7 days after completion of the comprehensive assessment.

The MDS coordinator will be responsible for assuring that the scheduling and completion of the MDS will be kept within CMS timeframes. Training for the nursing staff currently responsible for MDS completion was conducted on February 27, 2007. Training consisted of review of MDS time frames and discussion regarding interdisciplinary input and charting. Care plans need to be resident-specific and goal-oriented. Prior history will be reviewed in relation to current conditions and addressed on care plan. New care plan and old care plan will be reviewed to see if there has been a significant change of condition. All Care Plan meetings will also have summary sheets with interdisciplinary input and assignments given for follow-up (see attachment #14). RAP sheets need to be referenced by date and triggers must be dated and referenced material must be dated. Cross-training for back-up personnel will occur by March 30, 2007. Additional staff will be added to the MDS department to include a clerk so that an MDS calendar, all necessary signatures and the timely submission of MDS data can occur.

Comprehensive care plan training for all staff with input responsibilities and who make up the care plan team was conducted on February 27-28, 2007. CMS's RAI Version 2.0 manual has been printed and placed on each unit for staff reference. Training on the use of this manual was included in the comprehensive care plan training.

The Administrator, MDS Coordinator and IDT will ensure compliance at the time of all care conferences – admission, quarterly, and change of condition.

TARGET DATE: February 28, 2007, and ongoing.

§ 51.110.d.3. Comprehensive care plans

Action Plan: Services provided or arranged by the facility will meet professional standards of quality.

Comprehensive care plan training for all staff with input responsibilities and who make up the care plan team was conducted on February 27-28, 2007 (see attachment #6). CMS's RAI Version 2.0 manual has been printed and placed on each unit for staff reference. Training on the use of this manual was included in the comprehensive care plan training.

Nursing staff will weigh residents at the time of their admission and record on the admission assessment.

Diet tech will ensure compliance at the time of all care conferences – admission, quarterly, and change of condition and weight review.

TARGET DATE: February 28, 2007, and ongoing.

§ 51.120.a. Quality of care – Reporting of sentinel events

Action Plan: The facility management will report sentinel events to the Director of the VA Medical Center facility within 24 hours of identification and complete Root Cause Analysis within 45 days in accordance with State Veteran Home Patient Safety Improvement Handbook.

A concise policy will be written to define the reporting of all sentinel events within the guidelines and requirements from the Veteran's Administration. All sentinel events will be reported to the VA within 24 hours from the time it was noted as a sentinel event. An investigation and a written report will be completed and forwarded to the VA within 10 working days of the event. The ASVH Administrator will review and sign all reports that are to be distributed to agencies outside the facility.

An audit tool was developed for supervisor's to enable them to more consistently track incidents and document accurately (see attachment #15) and to assist the CQI Coordinator to capture all sentinel events for reporting and RCA purposes.

TARGET DATE: April 6, 2007, and ongoing.

§ 51.120.3.g. Quality of care – Mental and psychosocial functioning

Action Plan: The facility will ensure that a resident who displays mental or psychosocial adjustment difficulties will receive appropriate treatment and services to correct the assessed problem.

Social Service Supervisor will conduct a social worker team meeting on March 22, 2007, where the following will be reviewed:

1. Admissions Committee will identify any substance/alcohol/tobacco history of abuse and current practices.
2. All residents with history of substance abuse will be care planned, regardless of current use.
3. All residents will be interviewed and substance, alcohol and tobacco use documented. Screening will include type of substance, frequency of use, duration of use and any unusual habits that accompany the substance abuse. If tobacco abuse is indicated, then a complete smoking assessment will be completed and appropriate precautions taken.
4. Residents who continue to abuse the use of substances and alcohol will be referred for appropriate treatment.
5. If resident continue to abuse substances, treatment oriented discharge will be explored.

A wander guard policy and procedure (see attachment #8) for review and approval at the next Continuing Quality Improvement meeting scheduled on 3/20/07.

The MDS Coordinator and IDT will ensure compliance at the time of all care conferences – admission, quarterly, and change of condition.

TARGET DATE: March 22, 2007, and ongoing.

§ 51.120.3.i.2 Quality of care – Accidents

Action Plan: The facility will ensure that each resident will receive adequate supervision and assistance devices to prevent accidents.

A wander guard policy was developed (see attachment #8) and will be submitted to the Continuing Quality Improvement Committee on March 20, 2007 for review and approval.

A "Top Four" work group will meet each week on a unit to discuss the four issues of: restraint reduction, infection control, falls and wound care.

An audit tool was developed for supervisor's to enable them to more consistently track incidents and document accurately (see attachment #15).

The Administrator, CQI Coordinator and IDT will ensure compliance at the time of all care conferences – admission, quarterly, and change of condition.

TARGET DATE: March 20, 2007.

§ 51.120.k Quality of care – Hydration

Action Plan: The facility will provide each resident with sufficient fluid intake to maintain proper hydration and health.

An in-service will be conducted by the Diet Tech for all C.N.A.s and valets regarding the need for fluids at each meal according to resident preferences. In addition, it will be explained that proper hydration is defined as 30cc of fluids per kilogram (resident's weight); 25 cc for residents with congestive heart failure. At that time, RNAs will in-service C.N.A.s as to how to perform accurate and proper weighing and weight recording (see attachment #12).

The DON will conduct an in-service for nursing personnel to review current protocol for hydration which includes monthly uroscans.

Nursing staff will weigh residents at the time of their admission and record weight on the admission assessment.

The Diet tech and IDT will ensure compliance at the time of all care conferences – admission, quarterly, and change of condition.

TARGET DATE: April 6, 2007.

§ 51.130.e Nursing Services - Staffing

Action Plan: Nurse staffing will be based on a staffing methodology that is adequate for meeting the standards of appropriate call light response time.

On March 2, 2007, an all-staff in-service was conducted (see attachment #9) regarding call lights. Staff Developer will give agenda to non-nursing department managers who will then review with their staff that answering call lights is everyone's responsibility. Staff Developer will include this in the orientation for non-nursing personnel as well.

Beeper/personal pager technology for nursing staff was researched and will be reviewed by the Safety Committee (see attachment #13). If deemed advisable, it will be submitted to administration for approval.

A weekly staffing meeting is conducted on Tuesdays, 11:00 a.m. and recruitment/retention efforts will continue to be emphasized. Administration has recommended to Human Resources that nursing pool rates be increased. This is currently under review. Administration has approval from the Director for registry usage should that be necessary to maintain staffing standards.

TARGET DATE: April 6, 2007, and ongoing.

§ 51.140.c.1 Dietary services – Menus and nutritional adequacy

Action Plan: The facility will provide menus that meet the nutritional needs of the residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

Milk has not been placed on all residents' trays in the kitchen to ensure that each resident gets the milk listed on their tray ticket rather than the previous procedure of having the C.N.A.s distribute the milk at the time of tray delivery.

Pre-thickened juices, milk and water have been purchased to ensure that residents on thickened liquids will receive the correct consistently. Individual packets of thickener for coffee, cocoa, and any juices not already pre-thickened have also been ordered.

An in-service was conducted on 3/1/07 to ensure compliance with the above to include handling of special request items (see attachment #10). One person in the kitchen has been designated to check all trays for accuracy before leaving the kitchen. An tray audit was developed for this purpose (see attachment #11).

The Diet tech or trained designee will ensure compliance through random during meal observation and audits.

TARGET DATE: March 1, 2007, and ongoing.

§ 51.140.e Dietary services – Therapeutic diets

Action Plan: Therapeutic diets will be prescribed by the primary care physician.

The Dietician and the Diet Tech are reviewing all charts in the Home to make sure diets match the physician orders. All menu cards in the system are being updated, and this will be completed by 3/31/07.

It will be recommended on March 20, 2006, at the CQI Committee meeting to our Medical Director that all residents be placed on liberalized diets – consistency as tolerated in accordance with the move from a medical model of care to a social model.

The Diet tech will ensure compliance through review at all care conferences – admission, quarterly and with any change of condition.

TARGET DATE: March 31, 2007, and ongoing.

§ 51.180.d Pharmacy services – Labeling of drugs and biologicals

Action Plan: Drugs and biologicals used in the facility will labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructs, and the expiration date when applicable.

Nursing will do daily checks on insulin medication. The night shift nurse will clean the medication room refrigerator and remove all expired medication (i.e. insulin and PPD) on a weekly basis on Sunday and will document this on the INFECTION CONTROL: CLEANING AND TEMPERATURE SCHEDULE that is on the medication refrigerator door.

Infection Control Coordinator or trained designee will monitor for compliance.

TARGET DATE: April 6, 2007, and ongoing.

§ 51.190.a.1 Infection Control

Action Plan: The facility will establish and maintain an infection control program that will investigate, control and prevent infections in the facility as well as maintain a record of incidents and corrective actions related to infections.

The Infection Control nurse or designee will evaluate incidents of infections and record nosocomial infections. Infection Control nurse and the Infection Control Committee will meet weekly on each unit to investigate, control, and prevent infections in the facility. In a four week period, the Infection Control Committee will have evaluated every unit for nosocomial infections, noting any trending, and interventions implemented. Will continue to prevent the spread of infection by evaluating incidents of infection and determine the use of isolation precautions as needed. The facility will use the policy and practice guidelines as a reference as well as the PCP or Medical Director as needed.

The Staff Developer will continue to provide mandated annual infection control in-services and use infection control tracking to determine the need for any additional C.N.A., nursing or other staff in-services on infection control protocol.

Nosocomial infections, interventions, implementations and goals will be presented to the CQI committee on a quarterly basis. Infection control Policy and Procedure book will be reviewed and updated by April 6, 2007 by the staff developer and other disciplines as needed. The revision and updates will be reviewed by the DON for approval and a finalized review completed. This will be done annually and updates will be done as needed.

DON will do random audits to ensure compliance and report any out of compliance issues to the CQI committee as needed.

TARGET DATE: April 6, 2007, and ongoing.

§ 51.190.b Infection Control – Preventing spread of infection

Action Plan: The facility will isolate the resident if necessary to prevent the spread of infection. The requirement for hand hygiene will be monitored.

The Infection Control Policy and Procedure book will be reviewed and updated by April 6, 2007. The revision and updates will be reviewed by the DON for approval and a finalized review by the Administrator. This will be done annually and updates will be done as needed.

The Staff Developer or designee will provide all newly hired C.N.A.s with a competency skills checklist which needs to be completed and returned to the Staff Developer within 30 days of hire. Skill guidelines will also be provided by the C.N.A. for study reference. An annual certified nursing competency performance valuation will be completed thereafter. Hand-washing will be a skilled performance mandatory upon hire and annually thereafter.

All C.N.A.s will be given skill check offs on 3/15/07 and will be performing skills check offs which include hand-washing for the Staff Developer or designee. C.N.A. skill check off results will be kept by the Staff Developer.

The Infection Control Policy and Procedure book will be available at every unit and will provide direction and explanation on hand-washing.

The DON will do random audits to ensure compliance and report any out of compliance issues to the CQI committee as needed.

TARGET DATE: April 6, 2007, and ongoing.

§ 51.200.a Physical Environment – Life safety from fire

Action Plan: The facility will meet applicable provisions of the 1997 edition of the Life Safety code of the National Fire Protection Association. Storage will be maintained with an 18 inch clearance. Excess oxygen E-tanks will be stored properly Door wedges will not be used to hold doors open.

Engineering will install a red tape line 18" below the ceiling in the dietary storage rooms as a visual aid to ensure that no items are stored closer than 18" from the ceiling. This project will be completed by 3/8/07.

Door wedge was removed at the time of survey. Staff was instructed to not use door wedges to hold doors open. Engineering has been instructed to train staff on this issue whenever they see door stops being used. A sign-off sheet will be utilized to ensure compliance.

Oxygen tanks will be stored properly and were labeled "full" or "empty". Racks were provided for proper storage. Engineering will monitor oxygen tank storage on a daily basis, all units.

TARGET DATE: March 8, 2007, and ongoing.

ATTACHMENT #1

C.N.A Annual Competency Check Off

(Handwashing and at least four other skills will be selected for each C.N.A to demonstrate skill competency on an annual basis. Skills selection must include a skill in Pericare, psychosocial needs, vital sign demonstration, transfers, and meeting a ADL need that a resident may be deficient in. Skills may be performed in combination with other skills.)

C.N.A Name:_____

Date:_____

Skill	Demonstrates Competency	Requires additional Education	Comments
Handwashing			
How to start conversations and send messages			
Communicating with Residents who have hearing loss			
Communicating with residents who have problems with speech			
Assisting residents who have memory loss, confusion or understanding problems			
Assisting residents who are demanding or angry			
Moving the helpless resident to the head of the bed with one assistant			
Assisting resident to sit up on side of bed			
Assisting resident to transfer from chair to bed or bed to chair			
Assisting the resident with ambulation			

Making the unoccupied bed			
Making the occupied bed			
Tub/Shower bath			
Perineal care/ incontinent care- female with or without catheter			
Perineal care/ incontinent care- male with or without catheter			
Brushing teeth			
Denture care			
Mouth care of dependent resident			
Shaving the male resident (electric/ disposable)			
Hand and fingernail care			
Temperature/ Pulse/ Respirations			
Blood pressure			
Weight of resident			
Assisting resident with dressing, hair, combing, and application of prosthetic devices (example: glasses, hearing aides, dental devices, etc)			
Complete bed bath			
Feeding the dependent resident			
Assisting resident with use of bedpan			

Designated Observers Signature:_____

C.N.A Signature:_____

Plan:

ATTACHMENT #2

LAB AUDIT

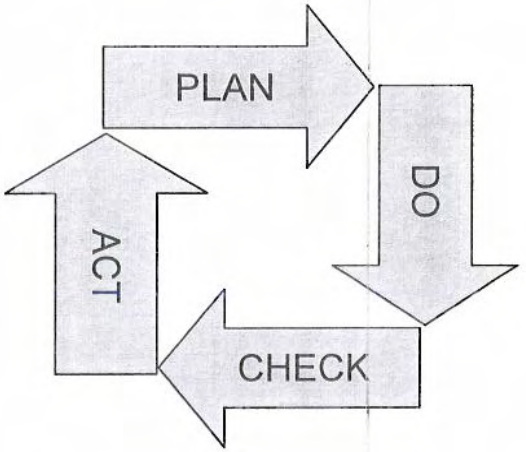
Rm #	Resident	Lab Test Ordered	Frequency	Date Last Done	Date According to Frequency		Date MD Notified	Copy on Chart		Next Due Date	Comments
					Yes	No		Yes	No		

ATTACHMENT #3

What is Quality, and how do we get there?

Arizona State Veteran's Home

Performance Improvement



For every man or woman
who has ever served
AMERICA,
we salute you

PLAN a change . . .
State objective
Document what is expected
Predict what will happen, why?
Plan to test the change

DO the change on a small scale . . .
Document problems
Begin analysis of collected data
OJT

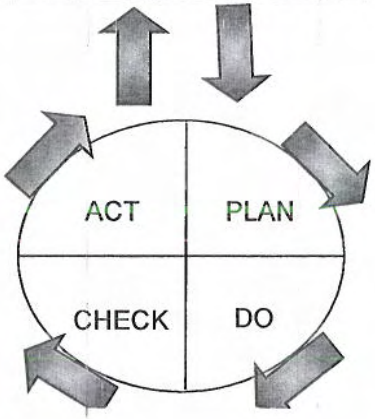
CHECK results . . .
Is the change working?
Complete data collection and analysis
Compare this data to predictions
Summarize and reflect what was learned

ACT . . .
Refine the change
Determine modifications
Formal training and policies

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?



ATTACHMENT # 5

Arizona State Veterans Home
Care Plan ~~Audit~~ Checklist

100% audit in 10 weeks

Resident's name: _____ Date: _____

Person conducting audit initials

Element of chart to be examined.	1st Q	2nd Q	3rd Q	4th Q
1. Accuracy of all pages of chart.				
2. MDS assessments have completed triggers and RAP sheet is dated.				
3. Nurse' notes, therapy notes, dietary notes and Social Service notes reflect issues that were triggered.				
4. Care Plans reflect issues to be addressed.				
5. All consents are present.				
6. Advance Directives are reviewed.				
7. Medications are reviewed and psychotropic medicines are looked at for accuracy in diagnosis, symptoms and side effects.				
8. The resident is discussed to assure that all issues are being addressed.				
9. PASARR's are evaluated to assure that, if a level II, recommendations are being followed.				
10. Prior MDS (for the past 15 months) will be reviewed for RN signatures				

Persons conducting audit:
(Please print)

_____
_____
_____
_____
_____
_____

ATTACHMENT 6

ARIZONA STATE VETERAN HOME – PHOENIX
PROGRAM ATTENDANCE SHEET

DATE 2-13, 2007

Program Topic: Care Planning Length: 30 min

Partners in Care (Video & discussion)

Presented by: [redacted]

PLEASE PRINT

(WITHOUT CLEAR, IDENTIFIABLE INFORMATION, YOU CANNOT RECEIVE CREDIT)

SIGNATURE	PRINT NAME	DEPARTMENT
1. [redacted]	[redacted]	
2. [redacted]	[redacted]	
3. [redacted]	[redacted]	
4. [redacted]	[redacted]	
5. [redacted]	[redacted]	
6. [redacted]	[redacted]	
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

CONTINUED ON NEXT SHEET.....

Training Summary of 2/13/2007

Partners in Care Video:
Presented by: Tom Perry

Training Goals:

1. Build knowledge of facility's care conference procedures and goals.
2. Build knowledge of the Care Plan team – function and members.
3. Build knowledge and familiarity with care plans and the care planning process.
4. Build knowledge of ways to encourage resident and family involvement in care conferences and care planning.

ATTACHMENT # 7

Care Plan Review:
100% audit in 10 weeks
Person conducting audit initials

Element of chart to be examined.	1st Q	2nd Q	3rd Q	4th Q
1. Accuracy of all pages of chart.				
2. MDS assessments have completed triggers				
3. Nurse' notes and Social Service notes reflect issues that were triggered.				
4. Care Plans reflect issues to be addressed.				
5. All consents are present.				
6. Advance Directives are reviewed.				
7. Medications are reviewed and psychotropic medicines are looked at for accuracy in diagnosis and symptoms.				
8. The resident is discussed to assure that all issues are being addressed.				
9. PASARR's are evaluated to assure that, if a level II, recommendations are being followed.				

Sign offs:

_____
_____
_____
_____
_____

ATTACHMENT #8

ARIZONA DEPARTMENT OF VETERAN SERVICES
ARIZONA STATE VETERAN HOME

DIVISION OPERATING INSTRUCTION 98-019 B

SUBJECT: PROTOCOL FOR USING WANDERGUARD SIGNAL DEVICE

EFFECTIVE DATE: April 1, 2007

1.0 PURPOSE: To ensure that staff understand and follow manufacturer's instructions for the WanderGuard signaling device to help reduce the risks associated with resident wandering.

2.0 POLICY: Each resident at risk of wandering will be monitored with the WanderGuard signaling device.

3.0 RESPONSIBILITY: The Social Service Director/Unit Social Worker or designee is responsible for ensuring that the devices are properly placed, used, rested by maintenance, removed, and properly disposed of following the Home's waste disposal policies.

4.0 PROCEDURE:

4.1. Placing signaling device.
- i. Nurse opens signaling device package and prepares device for placement following the instructions enclosed in the package.
- ii. Nurse document signaling device activation date and removal date in resident's chart.
- iii. All signaling devices are placed on the resident's wrist.

4.2. Testing Signaling Devices
- i. All staff is responsible for visually checking to make sure the device is on the resident and that the band is not frayed or loose.
- ii. All devices will be tested and if not working properly, the device will be removed from service.

4.3 Removing signaling devices.
- i. All signaling devices that test "inactive" will be removed immediately and disposed.
- ii. If a determination is made that the resident no longer presents a wandering risk, remove the Wandergard and discard it.
- iii. Record the date the device is removed in the resident's chart.

5.0 MAINTENANCE:

5.1 Engineering is responsible for the proper operation of Wanderguard equipment and will test the Wanderguard monitors weekly on each unit

6.0 IMPLEMENTATION:

6.1 Staff nearest the door at the time of the alarm will respond to the alarm each time it sounds.

6.2 Staff will reset the alarm only after the resident has been returned to the facility or it is determined that the alarm is "false".

7.0 DOCUMENTATION:

7.1 Care Plan Team is responsible for keeping accurate record regarding Wanderguard system use and maintenance.

7.2 Engineering will document operational status, preventive maintenance, and any repairs necessary.

_____
Catherine Corbin, Administrator

ATTACHMENT # 9

SAFETY & THE UNSAFE SMOKER

3/2/2007
LIBERTY HALL AND A107 FC

Type of meeting: ALL STAFF

Facilitator: Doris Pless

Agenda

SAFETY - WELL BEING

We are here to look out for the safety of all of our residents. We are their advocate. We need to communicate with each other, AND each department.

UNSAFE SMOKER

Describe what is an unsafe smoker?

- Smoke in their room,
- drop cigarette on themselves
- falls asleep while smoking
- does not make safe choices
- not able to hold the cigarette unaided
- history of sustaining burns to self and clothing r/t smoking.

What do you do as a staff member when you see a resident who appears to be unsafe while smoking?

- C.N.A.'s you report it to your nurse!
- Nurse- you assess resident if sustaining burns to clothing or self.
- Nurse notify Supervisor, family, MD , fill out incident report
- Notify Social worker readdress the ASVH smoking assessment.
- Ancillary departments notify nurses

What do you do as a staff member to ensure the resident safety during the smoking experience?

- Observe resident in their environment
- Offer smoking apron if needed
- Supervise smoke breaks

You all are the best – we are all here to take care of our Veterans and each other.

CALL LIGHTS:

- Everyone is responsible to answer a call light. All Department staff can answer a light. Yeah you can!!

- When answering the light , Knock on the door and tell them your name and ask them what they need.
- If it is not in your scope of your practice , tell them who you will be sending to their room.
- If it is something you can do – DO IT!!

Additional Information

Special notes:

ATTACHMENT #10

INSERVICE EDUCATION REPORT

TOPIC	INSTRUCTOR	DAY / DATE	TIME START	TIME END
TRAY TICKETS	[redacted]	THURSDAY 3/1/07	1:20 PM	1:40 PM

GENERAL OUTLINE

PUTTING THE RIGHT DIET AND SPECIAL REQUEST ITEMS ON THE TRAY

FOOD SERVICE DIRECTOR SIGNATURE

ATTENDEES PLEASE SIGN

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]
6. [redacted]
7. [redacted]
8. [redacted]
9. [redacted]
10. [redacted]
11. [redacted]
12. [redacted]
13. [redacted]
14. [redacted]
15. [redacted]
16. [redacted]
17.
18.
19.

PROGRAM INFORMATION: (RESOURCES OR MATERIALS USED, DEMONSTRATIONS, HANDOUTS GIVEN, SPECIAL NOTES, ETC.)

ATTACHMENT #11

TRAY AUDIT

DATE: ____________________

Observed by: ____________

Resident: ______________
Diet: __________________
Correct Beverage
yes ___ no ___
Correct Condiments
yes ___ no ___
Likes/Dislikes: __________
____

Resident: ______________
Diet: __________________
Correct Beverage
yes ___ no ___
Correct Condiments
yes ___ no ___
Likes/Dislikes: __________
____

Resident: ______________
Diet: __________________
Correct Beverage
yes ___ no ___
Correct Condiments
yes ___ no ___
Likes/Dislikes: __________
____

Resident: ______________
Diet: __________________
Correct Beverage
yes ___ no ___
Correct Condiments
yes ___ no ___
Likes/Dislikes: __________
____

Resident: ______________
Diet: __________________
Correct Beverage
yes ___ no ___
Correct Condiments
yes ___ no ___
Likes/Dislikes: __________
____

Resident: ______________
Diet: __________________
Correct Beverage
yes ___ no ___
Correct Condiments
yes ___ no ___
Likes/Dislikes: __________
____

ATTACHMENT #12

WEIGHT TRAINING
Scale Wgts, and Standing Wgts, and W/Chair Wgt
CHECK LIST

NAME _____ UNIT _____ SHIFT _____

I. PART A – Resources

Staff member acknowledges the following:

Information sources:
- Weight Sheet _____
- ADON _____
- Charge Nurse _____
- RNA Staff _____

II. PRACTICUM

The above named employee has completed review and return Demonstration for the following techniques:

- Zeroing out each individual scales _____
- Standing Residents on the scales _____
- Putting sling under resident properly _____
- Weighting W/C's before having Residents in them (W/Out any back packs on the back of W/Chair) _____
- Battery Replacement _____

_____ RNA Signature

_____ Date all training completed

I have reviewed and practiced the above Techniques, and agree to use the recommended Weighing methods for Resident, and Staff Safety.

_____ Staff Signature

_____ Date

[redacted]

Not going to use

Sample

D1 MONTHLY WEIGHTS

PRIOR WGTS	ROOMS	NAMES	WGTS #1	WGTS #2	SCALE USED
	D119P	[redacted]			SL
	D121A	[redacted]			ST
	D121B	[redacted]			ST
	D123A	[redacted]			ST
	D123B	[redacted]			SL
	D124A	[redacted]			ST
	D124B	[redacted]			SL
	D126A	[redacted]			SL
	D126B	[redacted]			SL
	D127A	[redacted]			
	D127B	[redacted]			
	D129A	[redacted]			SL
	D129B	[redacted]			ST
	D131A	[redacted]			ST
	D131B	[redacted]			SL
	D133A	[redacted]			SL
	D133B	[redacted]			ST
	D134A	[redacted]			SL
	D134B	[redacted]			SL
	D136A	[redacted]			SL
	D136B	[redacted]			SL
	D137A	[redacted]			SL
	D137B	[redacted]			ST
	D139A	[redacted]			SL
	D139B	[redacted]			

WEEKLY WEIGHTS			WGTS	XXXXXXXXX	SCALE USED

Catherine Corbin

Attachment #13

From: Mark Laney
Sent: Monday, March 05, 2007 5:10 PM
To: Catherine Corbin
Cc: Mike Landry; Jason Windish; Tammy Vogel
Subject: Emailing: cache

INTERPAGE

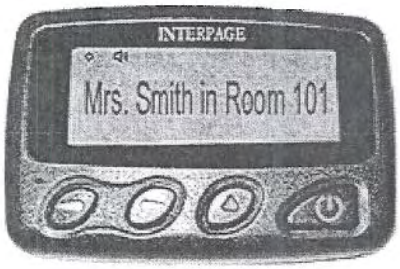
Wireless Paging Systems Call us toll free at 1-800-992-1000....**Inter Page**

Click Here to receive information on other Wireless Telecommunications System products.

1-800-992-1000

Healthcare Paging Systems

HOSPITALS, ASSISTED LIVING FACILITIES AND NURSING HOMES:



Enterprise Pager

INTER PAGE is an industry leader in on-site paging systems that integrate with:

- Old and new Nurse Call Systems (Jeron, Dukane, Rauland· TekTone, Executone, Wescom, West-Com, Zettler and othe
- Wandering Systems
- Fire, Security and Alarm Panels
- Infant Abduction Systems

On-Site Paging Systems or Pocket Paging System that are integrated afford the following benefits:

- Patients can contact their care giver in under two seconds
- Exact location of patient is sent to care giver
- Monitored exit security breaches are sent to responsible personnel
- Response times for patient care is greatly reduced
- Personnel have more efficient use of time
- Less personnel per shift are required to meet the patients' requirements
- Emergencies are handled more timely and efficiently
- Alert staff of potential problems in under two seconds
- Facilitate personnel in managing the buildings and grounds

Arizona State Veterans Home
Care Plan Meeting
Minutes

_____
Date

Resident's name: _____ _____

Attendees: _____ _____

_____ **Resident:** _____

_____ **Family:** _____

_____ **Other:** _____

Task :	Responsible Dept.	Target Date	Date Completed

Notes:

Family input:

ATTACHMENT #14

Supervisor Incident Report In House Audit Tool

Supervisor(s):_____ Date:_____

Completed in full	Comments or follow ups that need to occur	Agency notified during weekend occurrence by Nurse Supervisor	If answer yes to prior box please notify appropriate staff	Possibly Agency reportable	Appropriate interventions applied	Documentation in chart completed	POA, family, etc Notified	MD Notified	Injury	Occurrence	Resident	Room
		Time Date Agency Initial		Y or N (see attachment for reportable inc. definition.)	Y or N Care plan Updated Y or N	Y or N	Y or N	Y or N	Y or N MD order written if applicable Y or N			

ATTACHMENT # 15

ATTACHMENT #16

NAME ☐ Room Number

48 hr Check on All New Admissions: Date of admission:_____		COMMENTS
Compare hospital d/c orders with new admission orders for accuracy		
Compare admission orders with MAR and TARS for accuracy		
All orders must have diagnosis if applicable		
All new admissions physician order should include: level of care:		
If they are admitted with hospice they need to have admitted with Hospice (HOV) service and hospice diagnosis		
Flu ~~shoot~~ Shot order and if they have received it or not and approx date		
Pnemovax order and if they have received it or not and approx date		
2 step PPD order or have had a 2 step PPD within a year ;		
a annual 1 step PPD order is to be written		
Weekly skin assessment on TAR		
Diet order : carbon copy in chart and original to dining services		
If Skilled the standing orders must include: Admit to Skilled Services Rehab potential: i.e. fair, good PT/OT/ST eval and tx		
Orders faxed to pharmacy with face sheet		
Orders signed by physician		
Psychotropic consents if applicable		
Initial nursing assessment		
Nursing admission progress note, including verification of new med orders		
Temporary care plan		
Please initial that you have checked all requirements for new admissions as shown above or initial and write who it was referred to for completion		

Return to Medical Records within 24 hrs with corrections completed.

Nurse_____

cc: DON